Mississippi Board of Nursing
Recovering Nurse Program

VERIFICATION OF PRESCRIBED MEDICATION FOR RNP PARTICIPANTS

To the Health Care Provider of the Recovering Nurses Program Participant:

Please take a few moments to complete the form below. The form must document prescriptions, lack of prescriptions, and or samples dispensed. Please mail or fax the completed from to the Board office.

Fax: 601-664-9308
Mail: 1080 River Oaks Drive, Suite A100
Flowood, MS 39232-9779

If you have questions, please contact:
Marianne Wynn: (phone) 601-664-9331 or mwynn@msbn.state.ms.us; OR
Mike Long: (phone) 601-664-9318 or mlong@msbn.state.ms.us

Section A: To be completed by the RNP participant.

Date: _____
RNP Participant Name (Print):_____

RNP Participant Name (Signature): _____

Nursing License Number: _____Date of Birth: _____

Section B: The following section should ONLY be completed by the health care provider of the RNP participant.

_____ I acknowledge that my patient has informed me that she/he is participating in the Recovering Nurse Program and that use of opiates or other addictive drugs may trigger a relapse or prohibit the patient from working in the field of nursing while under the influence of certain medications.

Date: _____
Practioner's Name (Print): _____

Practioner's Signature: _____

Office Address: _____

_____

Office Telephone #: _____

Office Fax #: _____

RNP Participant's Name: _____

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VERIFICATION OF PRESCRIBED MEDICATION FORM

Reason for visit:_____

Date of visit, prescription date:	TYPE OF MEDICATION	Dispense Quantity	Dosage	# of Refills	Diagnosis	Expected Length of Treatment